STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155236	A. BUILDING _____ B. WING _____	R-C 02/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVON HEALTH & REHABILITATION CTR	**4171 FOREST POINTE CIR AVON, IN 46123**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS This visit was for a Post Survey Revisit (PSR) to the Investigation of Complaint IN00188020 completed on December 7, 2015. This visit was in conjunction with the Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on December 7, 2015. Complaint IN00188020- corrected. Survey dates: February 2 and 3, 2016. Facility number: 000141 Provider number: 155236 AIM number: 100283860 Census bed type: SNF: 2 SNF/NF: 101 Residential: 14 Total: 117 Census Payor type: Medicare: 14 Medicaid: 73 Other: 30 Total: 117 Sample: 6 Avon Health and Rehabilitation was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2-3.1 in regards to the PSR to the Investigation of Complaint IN00188020. Quality review completed 2/10/16 by 29479.	{F 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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